**ELITE COGNITION NEW CLIENT REFERRAL**

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| Referral Date: |
| Program Making Referral[ ] CCS [ ] CLTS [ ] DD [ ] CCF [ ] PS [ ] OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Service Facilitator/ Case Manager Information |
| Name: | Agency: |
| Address: | Phone Number: |
| Email: | Fax: |

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| Client/Consumer Information |
| Client’s Full Name: | Date of Birth:Current Age: |
| Client’s Gender: | Email: |
| Address: | Phone Number: |
| Diagnosis: (List all) |
| Does this individual have a history of suicidal ideation/ previous suicide attempts?  [ ] Yes [ ]  No [ ] Unknown | Does this individual have a crisis or behavioral plan in place? [ ] Crisis [ ] Behavioral  [ ] Yes [ ]  No [ ] Unknown |
| \*If this client is a minor or has a power of attorney- please complete the following: |
| Guardian/Parent’s Name: | Phone Number: |
| Address (if different than client): | Email: |

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| Service Need(s) |
| [ ]  Medication Management (non-prescriber)  | [ ]  Physical Health Monitoring |
| [ ]  Individual Skill Development & Enhancement | [ ]  Employment Related Skill Training |
| [ ]  Individual and/or Family  Psychoeducation | [ ]  Wellness Management and Recovery/  Recovery Support Services |
| [ ]  Psychotherapy | [ ]  Diagnostic Assessment: [ ]  BSP (Behavioral Support Plan) [ ]  Safety Protocol  [ ]  LEP (Law Enforcement Protocol) (Home/Community)  [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Client would prefer working with provider that is: [ ] Female [ ]  Male [ ]  No Preference |
| **Description of presenting barriers, needs, wants, goals and strengths.** ***(Be as specific as possible and use back of form if more space is needed).*** If “Yes” to Consumer questions above, please give additional information in this section.  |